Name: _____ **ID #:** _____

Agency: _____ **Vendor #:** _____

Health Identification and Planning System - Focused Review

MRDD ★★★★★ Quality Management

Date:

New Health Indicators:

☐Do Not Resuscitate Orders (DNR)
☐Alternative to Cardiopulmonary Resuscitation (CPR)
☐Significant or unexpected decline in Health or Behavior in the past year
☐Choking Precautions or difficulty chewing or swallowing
☐2 or more Medical Hospitalizations in the past year
☐Ventilator
☐Oxygen Therapy
☐Tracheostomy
☐Suctioning
☐Tube Feeding
☐Bowel Elimination Problems: ☐Colostomy ☐Ileostomy ☐obstruction or impaction
☐Bowel Elimination Problems: ☐Constipation ☐Diarrhea
☐Bladder Elimination Problems: ☐Catheter ☐Recurrent UTI (3+year)
☐Excessive Fluid Intake
☐PICA
☐Communicable Disease:☐TB☐Hepatitis A, B, C☐HIV ☐STD☐MRSA
☐Decubitus Ulcer or other Skin Breakdown
☐Seizure Disorder ☐Controlled ☐Uncontrolled
☐Vagus Nerve Stimulation
☐Dialysis
☐Falls on average 2+/month
☐Experiences Injuries on average 2+/month
☐Diabetes
☐ Insulin Usage
☐Anticoagulants
☐Weight concerns: ☐Difficulty maintaining ☐ Difficulty losing ☐Other weight concern
☐Immobility
☐Baclofen Pump
☐Recurrent Respiratory Infections (3 or more/year)
☐Chronic Pain
☐CPAP Continuous Positive Airway Pressure
☐Hypertension
☐Psychotropic Medications
☐Anticonvulsant Medications
☐Other:

Date last Nursing Review completed:

Information for Focus Review obtained by: ☐Home visit with consumer or ☐Telephone Consultation

Findings/concerns:

Recommendations:

Check all that apply:
☐Action taken on site and documented above
☐HIPS Action Plan initiated and attached
☐No additional action or follow up required
☐Other:

Completed by: **Date:**

Review and findings provided to:	

Name: _____ **ID #:** _____

Agency: _____ **Vendor #:** _____